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BEFORE THE
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: TESSIE TAGORDA RITUMBAN a.k.a., TAISIE TAGORDA a.k.a., TESSIE T. RITUMBAN 12252 Durango Court Victorville, CA 92392 Vocational Nurse License No. VN 179608 Respondent.	Case No. 6916 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Teresa Bello-Jones, J.D., M.S.N., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians (Board), Department of Consumer Affairs.

2. On or about February 3, 1997, the Board issued Vocational Nurse License No. VN 179608 to Tessie Tagorda Ritumban, also known as, Taisie Tagorda, and Tessie T. Ritumban (Respondent). The Vocational Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2006, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2875 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline the holder of a vocational nurse license for any reason provided in Article 3 (commencing with section 2875) of the Vocational Nursing Practice Act.

5. Section 118(b) of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated. Under section 2892.1 of the Code, the Board may renew an expired license at any time within four years after the expiration.

6. Section 2878 of the Code states:

"The Board may suspend or revoke a license issued under this chapter [the Vocational Nursing Practice Act (Bus. & Prof. Code, § 2840, et seq.)] for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual nursing functions.

. . . .

"(4) The use of excessive force upon or the mistreatment or abuse of any patient. For the purposes of this paragraph, 'excessive force' means force clearly in excess of that which would normally be applied in similar clinical circumstances.

. . . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Vocational Nursing Practice Act]."

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7. Section 2878.5 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter, it is unprofessional conduct for a person licensed under this chapter to do any of the following:

. . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to narcotics or dangerous drugs as specified in subdivision (b)."

8. California Code of Regulations, title 16, section 2518.5, states:

The licensed vocational nurse performs services requiring technical and manual skills which include the following:

. . . .

"(b) Provides direct patient/client care by which the licensee:

"(1) Performs basic nursing services as defined in subdivision (a)."

9. California Code of Regulations, title 16, section 2518.6, states:

"(a) A licensed vocational nurse shall safeguard patients'/clients' health and safety by actions which include but are not limited to the following:

. . . .

"(2) Documenting patient/client care in accordance with standards of the profession; and

. . . .

"(b) A licensed vocational nurse shall adhere to standards of the profession and shall incorporate ethical and behavioral standards of professional practice which include but are not limited to the following:

"(1) Maintaining current knowledge and skills for safe and competent practice;

"(2) Maintaining patient/client confidentiality;

"(3) Maintaining professional boundaries with the patient/client; and

. . . .

"(c) A violation of this section constitutes unprofessional conduct for purposes of initiating disciplinary action."

10. California Code of Regulations, title 16, section 2519, states:

"As set forth in Section 2878 of the Code, gross negligence is deemed unprofessional conduct and is a ground for disciplinary action. As used in Section 2878 'gross negligence' means a substantial departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent licensed vocational nurse, and which has or could have resulted in harm to the consumer. An exercise of so slight a degree of care as to justify the belief that there was a conscious disregard or indifference for the health, safety, or welfare of the consumer shall be considered a substantial departure from the above standard of care."

11. California Code of Regulations, title 16, section 2520, states:

"As set forth in Section 2878 of the Code, incompetence is deemed unprofessional conduct and is a ground for disciplinary action. As used in Section 2878 'incompetence' means the lack of possession of and the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by responsible licensed vocational nurses."

12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

13. CONTROLLED SUBSTANCES

A. "Ativan," is a brand of lorazepam, a benzodiazepine. It is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (D) and is categorized as a "dangerous drug" pursuant to Business and Professions Code section 4022.

B. "Tylenol," is a brand name for acetaminophen. It is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(2) and is categorized as a "dangerous drug" pursuant to Business and Professions Code section 4022.

FACTUAL SUMMARY

Patient O.L.D.

14. On or about January 7, 8, and 9 of 2003, Respondent was working as a licensed vocational nurse at the Veteran's Home of California - Barstow, California (VHCB). Respondent was assigned to provide care to Patient O.L.D. on January 7, 8, and 9, 2003. Patient O.L.D. was an 80 year old man, admitted on October 18, 2002, with diabetes, chronic obstructive pulmonary disease, degenerative joint disease, and anemia.

15. On or about December 1, 2002, Patient O.L.D. began gastrostomy tube (G-tube) feedings of 90cc Glytrol, an hour for 20 hours a day. The nurses notes from December 23, 2002 to January 6, 2003, revealed that the patient tolerated the G-tube feeding well with no documentation of nausea or vomiting. On December 23, 2002, physicians orders were for Tylenol 500 mg. every 6 hours, as needed for pain and Ativan 0.5./tablet every 8 hours, as needed for anxiety.

16. On or about January 7, 2003, Patient O.L.D. began having emesis, abdominal pain, and was started on a mechanical soft diet. The G-tube feeding orders were changed to run only 110cc/hour for 10 hours, begin at 1900 hours, and end at 0500 hours.

17. On or about January 8, 2003, at 8:00 p.m., Respondent received a report from a nursing assistant that Patient O.L.D. had severe abdominal pain. Respondent medicated Patient O.L.D. with Tylenol 500 mg. and documented the medication was given for generalized pain. Respondent failed to document that he had assessed the cause or nature of the pain or had any verbal interaction with Patient O.L.D. Respondent failed to notify the physician of Patient O.L.D.'s severe pain.

18. On or about January 9, 2003, Respondent charted "1:00 a.m., 1-9-03, CNA reported to this writer that resident had vomited. Noted yellow sticky fluids in small amount. Feeding held at this time. No residual noted when checked. No abdominal distension noted. Resident vomited again after feeding was held with same color and consistency." Respondent failed to document that she checked for bowel sounds, abdominal distention, gastric residuals, or examined the abdomen for any abnormalities after the second emesis. Respondent failed to

record any verbal interaction with Patient O.L.D. and ask about any discomfort or pain. Respondent also failed to document Patient O.L.D.'s lowering blood pressure, increasing pulse, and respiratory rate.

19. On or about January 9, 2003, Respondent notified the Nurse Practitioner at 01:25 hours and documented "called NP on duty. Made aware of above with no orders. Stated to check residuals and hold feedings." Respondent failed to write the Nurse Practitioner's statements as an official order on the physician's order sheet. Respondent held the tube feedings for a while, but then at 02:05 hours, documented "G-tube feeding resumed at this time. Will continue to observe." Respondent failed to document that she checked for gastric residuals prior to resuming the feeding, performed any other assessment of the abdomen, bowel sounds, or asked Patient O.L.D. about nausea, discomfort or pain. Respondent documented at 05:00 hours, "feeding turned off. Patient O.L.D. awaken easily when feeding was turned off. Noticed linens with small amount of sticky yellow fluid." Respondent failed to document that the Nurse Practitioner or the physician were notified of the continued vomiting or that the feeding tube had been turned back on, without orders, and continued to run from 02:50 hours until 05:00 hours. Respondent failed to document that she assessed Patient O.L.D. for continued vomiting, nausea, bowel sounds, gastric residual or pain, after the last emesis.

20. On or about January 9, 2003, at 13:15 hours, Patient O.L.D. was examined by a supervising physician and was diagnosed with a non-reducible strangulated right inguinal hernia and ordered Patient O.L.D. to be sent to an acute care facility for surgery. On or about January 9, 2003, at 18:46 hours, Patient O.L.D. died due to cardiac arrest secondary to sepsis and strangulated right direct inguinal hernia with a gangrenous segment of small intestine.

Patient B.M.

21. On or about December 1, 2002 through December 4, 2002, Respondent was working as a licensed vocational nurse at VHCB.

22. Patient B.M. was a 78 year old man, admitted on June 7, 2002, with coronary atherosclerosis (hardening of arteries), coronary artery disease (CAD), congestive heart failure (CHF), chronic obstructive airway (pulmonary) disorder (COPD), and depression.

23. On or about November 1, 2002, Patient B.M. complained of shortness of breath and was transferred to Barstow Community Hospital (BCH). Patient B.M. was stabilized and released on November 4, 2002, to VHCB.

24. The nursing notes from November 26, 2002 through December 3, 2003, indicate that Patient B.M. had continued to refuse most of his food and that his general condition had declined to the point that he could no longer feed himself and required to be spoon fed. On December 1, 2002. Respondent was assigned to care for Patient B.M. on December 1, 3, and 4 of 2003. The nursing staff requested that all Patient B.M.'s meals be pureed, as he could no longer chew. The nursing notes indicate that Patient B.M. was found in a fetal position, in bed, with feces on his hands and linens. Patient B.M. refused to get out of bed to be cleaned. This information was relayed to Respondent.

25. On December 3, 2002, at 02:30 hours, Respondent indicated in the nursing notes that Patient B.M. was found sitting on the floor and stated that he attempted to get out of bed to use the restroom, but his legs gave out. Patient B.M.'s blood pressure at that time was 72/44. Respondent failed to notify the physician of the low blood pressure and Patient B.M.'s increased weakness. The nursing notes indicate that Respondent notified the family and the physician of Patient B.M.'s fall at 06:35 hours.

26. From November 4, 2002 to December 4, 2002, there was no nursing care plan indicating that Patient B.M. was to be monitored due to the initiation of Digoxin therapy on November 4, 2002 and his increased weakness.

27. On December 3, 2002, at 11:00 hours, Patient B.M.'s blood pressure was 84/62. There was no documentation on the MAR to indicate that Respondent had checked Patient B.M.'s pulse prior to administering the 09:00 hours Digoxin dose. The physician progress note indicates that Patient B.M. was started on Digoxin on November 4, 2002, by the BCH physician, upon re-admission. Dr. C. Mlot indicated that he was not aware that B.M. was on Digoxin, because he was not on this medication before November 4, 2002. He also indicated that he was concerned about the levels and plans to check the Digoxin level. On November 14, 2002, Dr. C. Mlot wrote an order to hold the Digoxin, if the pulse was less than 55/min. Based

on Respondent's own charting in Patient B.M.'s record, Respondent's giving of Digoxin on December 3, 2002, was not in compliance with the physician's order.

28. On December 4, 2002, at 10:00 hours, the nursing notes indicate that the blood pressure was 50/56. There was no documentation to reflect that the nursing staff notified the physician of the low blood pressure. However, the MAR indicates a note from the nurse indicating the low blood pressure and that the physician was notified. The physician ordered the Digoxin level to be drawn. The laboratory report reflected that Patient B.M.'s Digoxin level was 8.54 (normal 0.8 to 2.0). The nursing notes revealed that the physician was notified of the elevated serum Digoxin level at 10:54 hours and examined him at 11:00 hours. The blood pressure was 50/34, a pulse at 81 and irregular, with a respiratory rate of 26/min. The physician ordered Patient B.M. to be transported to BCH, due to hypotension and an elevated Digoxin level. Paramedics arrived and transported Patient B.M. at 11:09 hours. The paramedics noted that Patient B.M.'s vital signs were blood pressure at 56/36, pulse at 80, slow and irregular, respiratory rate at 22, with wheezes and Patient B.M. was feeling terrible. The emergency notes indicate that at 11:39 hours, Patient B.M. developed a cardio-respiratory arrest and CPR was initiated. The Digoxin level was 8.54 at that time. At 11:40 hours, various cardiac medications and one vial of Digibind was administered along with repeated defibrillations. At 12:07 hours the code was called off and Patient B.M.was pronounced dead.

FIRST CAUSE FOR DISCIPLINE

(Incompetence or Gross Negligence)

29. Respondent's license is subject to disciplinary action for unprofessional conduct pursuant to section 2878, subdivision (a)(1), as defined in California Code of Regulations, title 16, section 2519 and 2520, in that Respondent demonstrated incompetence or gross negligence, in her care of Patient O.L.D. and B.M., as stated above in paragraphs 14-28.

SECOND CAUSE FOR DISCIPLINE

(Mistreatment or Abuse of Patient)

30. Respondent's license is subject to disciplinary action for unprofessional conduct pursuant to Section 2878, subdivision (a)(4), for violating California Code of

Regulations, title 16, sections 2518.5, subdivision (b)(1), 2518.6, subdivisions (b)(1), (2), (3) and (c), in that Respondent failed to act as Patient O.L.D. and B.M.'s advocate and failed to follow facility policy and standards of practice, by failing to provide quality treatment, keep patient free from harm or injury, and provide care that complied with facility policy and standards of practice, as more fully set forth above in paragraphs 14-28 above.

THIRD CAUSE FOR DISCIPLINE

(Falsified, Made Grossly Incorrect or Grossly Inconsistent Entries in Hospital Records)

31. Respondent's license is subject to disciplinary action for unprofessional conduct pursuant to Section 2878, subdivision (a), on the grounds of unprofessional conduct, as defined in Business and Professions Code, section 2878.5, subdivision (e), in that Respondent falsified, made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records pertaining to controlled substances and dangerous drugs, as more fully set forth above in paragraphs 14-28.

FOURTH CAUSE FOR DISCIPLINE

(Violation of Standards of Practice)

32. Respondent's license is subject to disciplinary action for unprofessional conduct pursuant to Section 2878, subdivisions (a) and (d), in that Respondent's actions were a violation of the standards of practice that resulted in O.L.D. and B.M.'s death, as more fully set forth in paragraphs 14-28 above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Vocational Nurse License No. VN 179608, issued to Tessie Tagorda Ritumban, , also known as, Taisie Tagorda, and Tessie T. Ritumban;

2. Ordering Tessie Tagorda Ritumban to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: July 10, 2006

TERESA BELLO-JONES, J.D., M.S.N., R.N.
Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
State of California
Complainant

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